ASSERTIVE COMMUNITY TREATMENT (ACT)
FIDELITY REPORT

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AHCCCS Fidelity Reviewers

Method

On August 9th-10th, 2016, Georgia Harris and T.J. Eggsware completed a review of the Partners in Recovery- West Valley Assertive Community Treatment (ACT) team. This review is intended to provide specific feedback in the development of your agency's ACT services, in an effort to improve the overall quality of behavioral health services in Maricopa County.

Partners in Recovery (PIR) serves individuals with Serious Mental Illness (SMI) through seven locations in Maricopa County: Metro, West Valley, Hassayampa, East Valley, Arrowhead, Gateway, and West Indian School (which houses the ACT team that was previously located at the Arrowhead Clinic). Since last year's review, the PIR West Valley campus ACT team endured significant staffing turnover. Apart from the Psychiatrist, the team reports that the majority of the team's staff have joined in the past eight months with some as recent as the first day of the fidelity review. In addition, the team has had to rely on the support of temporary staff in multiple positions to sustain services, particularly in instances where staff were inactive due to medical leave.

The individuals served through the agency are referred to as "clients", but for the purpose of this report, and for consistency across fidelity reports, the term "member" will be used.

During the site visit, reviewers participated in the following activities:

- Observation of the daily ACT program meeting (i.e., morning meeting).
- Individual interview with the ACT team leader (i.e., ACT CC).
- Individual interviews with the lead Substance Abuse Specialist (SAS), Peer Support Specialist (PSS) and Housing Specialist (HS).
- Interviews with five members receiving services from the ACT team, consisting of two small group interviews with four members, and one individual interview.
- Charts were reviewed for ten members using the agency's electronic medical records system.
- Reviewed team documents such as: *PRG.40 Case Closure and Re-Engagement Activities Prior to Disenrollment*; *Outreach Protocol Audit*; *Alpha ACT Morning Meeting* log; ACT team census reporting from 3/25/16-8/5/16; *Illness Management and Recovery Session Guidelines*;

ACT team brochure; *ACT Presentation for the Doctor* and the *PIR West Valley Campus Group List*.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) ACT Fidelity Scale. This scale assesses how close in implementation a team is to the Assertive Community Treatment (ACT) model using specific observational criteria. It is a 28-item scale that assesses the degree of fidelity to the ACT model along 3 dimensions: Human Resources, Organizational Boundaries and the Nature of Services. The ACT Fidelity Scale has 28 program-specific items. Each item is rated on a 5-point scale, ranging from 1 (meaning *not implemented*) to 5 (meaning *fully implemented*).

The ACT Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- Nurses on Staff: The ACT team benefits from having two, full-time nurses on staff. In addition to primary care physician (PCP) coordination and medication administration, both nurses equally provide community-based services to members.
- Small Caseload: The team maintains the low member-to-staff ratio of 9:1. Equipped with ten staff, the team is of adequate size to consistently provide staffing diversity and coverage.
- Peer Support Specialist: The Peer Support Specialist (PSS) provides direct care services. The PSS shares his personal recovery experiences with members, and additionally provides language interpretation services for ACT members in need of English-to-Spanish translation.
- Team Communication: The agency provided a text communication tool for staff which they cited as beneficial in staff coordination.

The following are some areas that will benefit from focused quality improvement:

- Continuity of Staffing: The ACT team experienced an above 100% staff turnover rate in the past two years. The circumstances of the staffing vacuum were unclear to reviewers. The team, provider agency administration, and the RBHA should collaborate to define the root causes for this extreme turnover. Consistent staffing intensifies team unity, and improves therapeutic rapport with members. The team should explore and implement practices to assess potential candidates for suitability. The agency should also investigate any correlations that may exist in the staff turnover patterns, or the effects of agency policies on staff retention.
- Records and Documentation: ACT staff attributed their lack of documentation to their extended staffing shortage, and a period of intermittent technical issues. Though staff said they spend most of their day fulfilling the functions of their specialties, the absence of notes in the member records has impacted their ability to demonstrate proficiency in hospital admission/discharge coordination, intensity of services, and frequency of contact with members. Train all ACT staff on the various documentation requirements and provide them with strategies, schedules and other aids to meet these objectives.
- Individualized Substance Abuse Treatment: The ACT team does not currently provide individualized substance abuse treatment. Prior to the recent hiring of the Substance Abuse Specialist (SAS), the team strongly relied upon external providers for substance abuse treatment. Now that there is an experienced SAS on the team, the team must transition from referring to external providers to providing treatment that directly addresses the concurrent effects of co-occurring disorders.

ACT FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
H1	Small Caseload	1 – 5 5	The ACT team maintains a low member-to-staff ratio of 9:1. The team serves 91 members and has 10 staff. The staff composition is as follows: one ACT Clinical Coordinator (ACT CC), one Rehabilitation Specialist (RS), one Employment Specialist (ES), one Housing Specialist (HS), one Independent Living Skills Specialist (ILS), one Substance Abuse Specialist (SAS), one Peer Support Specialist (PSS), two Nurses (RNs), and one ACT Specialist/Mental Health Worker (MHW). This count excludes the Psychiatrist and the Program Assistant. Two staff were out on leave, and temporary staff filled their positions.	
H2	Team Approach	1 – 5 4	The team frequently shares responsibility for all members, but occasionally resorts to a traditional case management model. Staff are scheduled to visit members using a zone scheduling system; however, staff stated that the high staff attrition rate lessened their ability to provide specialized care to members. Staff estimated that in the most recent two week period, members were served by multiple ACT specialists about 70% of the time. The results of the chart review echoed the 70% estimate that was provided by the ACT staff.	• Maintaining an adequate program size of ten staff and reducing staff turnover, are critical to the foundation of a successful ACT team. Having this foundation increases stability for members and allows enough flexibility for staff to function in their specialties.
H3	Program Meeting	1 – 5 5	The team meets five days a week for their morning meeting. The meeting is two hours in duration. It is expected that all ACT staff attend the meeting. All members are discussed daily.	• Maintaining a brisker pace of discussion in the program meeting may allow staff more time to provide community-based services.
H4	Practicing ACT Leader	1 – 5 2	The ACT CC joined the team in June 2016. Based on the data provided, the ACT CC provides services to members on rare occasions. Of the ten member records reviewed, the ACT CC was listed as the	• The CC should spend 50% or more of her time providing direct services to members. A practicing ACT Team Leader is noted as one of the five

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			service provider in one face-to-face encounter. The ACT CC reported that she had an assigned caseload until recently, and estimated that she spends between 40-50% of her time providing direct services to members. The reviewers requested a copy of the ACT CC's face-to-face encounter reporting; however, it was not provided. The lack of verifiable is reflected in the score.	factors most strongly related to better member outcomes. As the ACT CC establishes her role on the team, increasing her time spending direct services will offer opportunities to model appropriate clinical interventions for the other ACT staff. • Identify and address barriers to the ACT CC providing at least 50% of the time in direct services.
H5	Continuity of Staffing	1 – 5 1	The ACT team experienced more than 100% turnover in the past two years. Reviewers experienced difficulties in obtaining accurate data for this scoring item. Staff reported that the turnover rate was comprised of staff who resigned and staff who were terminated from their positions; temporary staff filled some positions. Staff were unaware of the historical factors leading up to the staffing vacuum experienced by the team; at least seven of the eleven current ACT staff were hired in 2016 alone. Members were also unaware of the issues faced by previous staff; however, they were fully aware that they had "lost an entire team" in the past year. One member came prepared to the interview with a list of staff he hoped would remain with the team.	• Examine employees' motives for leaving the team. Employee exit interviews can help to determine trends in employee turnover. This may be an area of further ongoing provider agency, clinic and system review. • As new candidates are being reviewed, consider implementing experiential hiring practices such as job shadowing for potential new ACT team staff, particularly for those job candidates new to the ACT model.
H6	Staff Capacity	1 – 5 2	Over the past 12 months, the team endured many staffing variations which, in turn, affected their ability to provide multidisciplinary services. Some of the position vacancies were the result of current specialists moving into other positions on the team, requiring the team to use temporary staff to fill the newly created openings. The ACT team was unable to provide accurate reporting of their staff vacancies. With the data provided, it	• See recommendations for continuity of staffing (H5). Maintaining a fully-staffed team is critical to the service consistency for members. When there are position vacancies, members are unable to receive the breadth of essential services, as advertised by the ACT team.

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			was calculated that the team had 64 vacancies in the past 12 months, resulting in a 55.6% staff capacity.	
H7	Psychiatrist on Team	1 – 5 4	The team benefits from a full-time, fully-integrated Psychiatrist. In addition to psychiatric medication and monitoring, she coordinates care between PCP and specialty medical services for members. During the daily team meeting, she was observed directing team decisions for member engagement and service interventions. Though she is clearly engaged with the team, she is the lead Psychiatrist at the clinic, which has created some additional demands on her time. The Psychiatrist is required to attend a number of monthly meetings and has been covering a team in another clinic on a weekly basis.	• Full fidelity in this item is tied to the complete dedication of the ACT Psychiatrist to the services of ACT members only. To fulfil this requirement, the agency should consider having another Psychiatrist assigned to cover teams with vacancies (e.g. Locum Tenens, float, etc.).
H8	Nurse on Team	1 – 5 5	The team currently has two full-time RNs. Both RNs shoulder an equal amount of tasks and responsibilities for the members. Both the staff and members view the RNs as flexible and accessible. The RNs provide physical/behavioral health education, PCP/specialty coordination, and home visits to members when necessary.	
H9	Substance Abuse Specialist on Team	1 – 5 3	The team has one, full-time Substance Abuse Specialist (SAS). The SAS has previously worked as an SAS on another ACT team, and she has prior experience working as a co-occurring specialist for a dual-diagnosis treatment program, in addition to being a Licensed Master Social Worker (LMSW).	• Each 100-member ACT team should have two SASs with at least one year of verifiable substance abuse training or supervised substance abuse experience. The agency should recruit for the second SAS as soon as possible.
H10	Vocational Specialist on Team	1 – 5 3	The team has both an Employment Specialist (ES) and a Rehabilitation Specialist (RS). The ES started on the ACT team on the first day of the review. Her qualifications/experience could not be confirmed. The ACT CC reports that the RS has had 15 years of experience in rehabilitation work.	• Ensure that both Vocational Specialists have at least one year of verifiable training or experience in vocational rehabilitation and support.

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H11	Program Size	1 – 5 5	The ACT team consists of 11 full-time staff for 91 members. The team is positioned to provide adequate coverage to the members served.	
O1	Explicit Admission Criteria	1 – 5 4	The team has developed a tool identified as the *ACT Assessment Presentation for the Doctor*, which is used to gather member information pertinent to the team Psychiatrist. The ACT staff were unfamiliar with the *MMIC ACT Admission Screening Tool*; however, the staff felt that aside from the occasional administrative transfer to the team from the RBHA, the ACT team makes the final decision on appropriate admissions.	• Establish clearly defined, written criteria for ACT eligibility. Well defined criteria are essential when training new ACT staff to verify the ACT appropriateness of potential members.
O2	Intake Rate	1 – 5 4	The ACT team takes members in at a moderate rate. A combination of the team's completed *ACT Fidelity Review Data Collection Sheet* and an ACT team census report were used to calculate the score for this item. There was discrepancy between member intake data provided prior to the review, and data provided at the time of the review. It was determined that the month with the highest number of admissions was April 2016, with a total of seven admissions.	• The ACT team should maintain a low intake rate by limiting the number of member admissions to a maximum of six per month.
O3	Full Responsibility for Treatment Services	1 – 5 2	In addition to case management, the team is responsible fully provide psychiatric services. With regards to substance abuse treatment , the team provides group but not individual treatment). The team does not provide counseling and/or psychotherapy at this time; members who are in need of counseling are referred to external providers. More than 10% of members are in residences with some staff support, or are pending referral to that type of setting. The team reports that vocational services are provided, but it is not clear if vocational service staff have specific training in the area, and the team was observed	• The ACT team should be fully integrated and capable of providing the majority of services to members, without referral to external sources. • Train existing staff to function in their areas of specialty, empowering them to tailor services to each member's specific needs.

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			proposing referrals to external employment agencies for services.	
O4	Responsibility for Crisis Services	1 – 5 3	The ACT CC views the team as the first responder to crisis situations. Members have the list of staff phone numbers; they are free to call the on-call number after hours. Though the team offers on-call services to members, ACT staff described their many challenges to providing those services. For a number of weeks, the staffing shortage affected their ability to rotate the on-call phone. It was reported that at one point, a single staff member had the on-call phone for more than 30 days consecutively, and during that timeframe staff reported it wasn't "necessary" for them to go into the field to support members. This limited rotation reduced on-call services to verbal de-escalation by phone, by the on-call staff. It appears the team has not had the ability to provide crisis services in the field but primarily served in a consultative role.	• Now that the team is staffed near to capacity, work on creating an on-call rotation that equally distributes responsibilities among all ACT staff. • Educate members about the crisis call process, so that all know the dedicated number rather than calling any preferred staff.
O5	Responsibility for Hospital Admissions	1 – 5 3	The ACT team was involved in four of the ten most recent hospitalizations. In two of the last ten hospitalizations, the members self-admitted to the hospital. Some of the admissions occurred before	• Monitor and track member hospitalizations closely. ACT team involvement in the decision to

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			the current CC joined the team. The data for four of the last ten hospitalizations was unavailable to reviewers. The lack of accurate data was reflected in the score. The ACT CC reports that the team works with the doctor to triage member needs, coordinating voluntary hospital admissions whenever possible.	hospitalize members helps to ensure that members are only admitted when appropriate.
O6	Responsibility for Hospital Discharge Planning	1 – 5 4	The ACT team was involved in eight of the ten most recent hospital discharges. The data for two of the ten most recent discharges was unavailable to reviewers. The lack of accurate data was reflected in the score. The ACT CC reports that the team is involved in the discharge process upon hospital admission. The team works with the inpatient doctors to coordinate treatment, and also works with the social workers to establish a discharge plan. Once discharged, the team will transport the member safely home, and ensure they have medications and basic necessities, such as food.	• Monitor and track member discharges closely. Accurate tracking of hospital discharges is pertinent to effective coordination of follow-up care for members.
O7	Time-unlimited Services	1 – 5 5	The team rarely closes cases, but remains a point of contact for members who choose to terminate ACT services. The ACT team reports that none of their members have graduated in the past 12 months. The ACT CC anticipates that approximately three members will graduate in the next year. Staff also gave examples of members who have left the past year and have re-enrolled with the team after closure.	
S1	Community-based Services	1 – 5 3	Members are being served by the ACT team in both the clinic and in the community. Based on the records reviewed, the team performed 50% of all face-to-face contacts in the community. Interviews and the record review also indicated that the team performs a significant proportion of their	• Work towards making 80% of all face-to-face contacts with members in the community. • Ensure that all encounters with members are accurately documented within the clinical record.

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			medication management and skills training groups inside the clinic. Members reported seeing staff in both the clinic and community settings in equal proportions. Staff interviewed estimated that they are providing services in the community between 75-80% of the time. When asked about the incongruent reporting between sources, some staff said their ability to meet with member in the community was diminished while their team was rebuilding.	• Work towards moving skills training and/or didactic services into community settings. Member outcomes improve when new skills are taught in the settings where they naturally occur. • Substance use treatment groups will likely occur in the clinic setting, but resist creating other groups in the clinic setting, focusing on individualized services in the community.
S2	No Drop-out Policy	1 – 5 4	The team has retained approximately 90% of their members in the past 12 months. Of the members who left the team, two refused ACT services and seven could not be located by the ACT team.	• For members who have lost contact with the team, continue to use assertive engagement mechanisms to locate them. See S3, Assertive Engagement Mechanisms, for additional recommendations.
S3	Assertive Engagement Mechanisms	1 – 5 4	Staff reported that they use a 12-week contact strategy for disengaged members. This strategy requires ACT staff to contact a list of facilities and/or drive to locations frequented by the missing member. Though the strategy was verbally described to reviewers by the staff, the chart review did not reflect such efforts. In fact, the chart review indicated that the strategy was being used more sporadically than was reported by the team. Reviewers requested a copy of the written outreach strategy but did not receive it prior to the specified deadline, but did receive the *Outreach Protocol Audit* form that has spots to track nine outreach dates.	• Create or locate the existing outreach protocol. Ensure that all staff understand its parameters and are accurately documenting their efforts in the clinical record.
S4	Intensity of Services	1 – 5 2	The available data indicates that members receive an average of 43.38 minutes of face-to-face contact per week. The chart review indicated that staff most frequently met with members for brief	• ACT teams should average two hours or more per week of face-to-face contact with members. Due to high staff turnover, and the addition of new staff,

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			encounters. Additionally, members stated that they met primarily with staff for cursory events, such as medication monitoring. Staff explained to reviewers that the extended gaps in their staff roster compromised their ability to provide intense levels of service to members. Consequently, staff were relegated to provide basic, case management services rather than intense, specialized care.	building rapport with members should be a primary area of focus moving forward and maintaining a higher intensity of services delivered by the team rather than outside agencies should aid in the effort. • The ACT team and agency administration should explore the systemic, technological, and human resource needs of the ACT team, subsequently assisting to find solutions to the needs that create gaps in services for members.
S5	Frequency of Contact	1 – 5 2	The team currently provides a low frequency of contact to members. Of the ten records reviewed, ACT staff averaged two contacts per week, per member. Members report that face-to-face contacts with staff are sporadic, often only increasing when they are receiving medication management services. The ACT CC informed reviewers of the staffing and technological difficulties experienced by the team, which she believes factored into the team's infrequent reporting of their encounters with members.	• ACT teams should average four or more face-to-face contacts per week, per member so staff are more aware of member status, identifying potential areas of crisis or concern earlier, and can offer support. • ACT staff must consistently document all encounters with members in the clinical record for improved team coordination and continuity of care. See S4, Intensity of Services, for recommendations on the agency's role in service improvement.
S6	Work with Support System	1 – 5 1	The ACT team provides minimal support to the members' informal support systems. During the morning meeting, reviewers observed the team discussing opportunities to outreach informal member supports, but it was not clear if recent contact occurred, or was only planned to occur. Staff suspected that they were in contact with member supports at least once monthly. Though the staff could identify the informal supports they	• Educate members on the benefits of, and encourage the involvement of, informal supports. • If a member has an identified support, but declines to sign a release of information (ROI) for team engagement, this should be documented in the member record for future reference. Revisit this option

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			most frequently connect with, the documentation to support this was minimal. Of the ten member records reviewed, one record displayed evidence of staff contact with informal supports. In addition, members interviewed felt that staff had minimal contact with informal supports, some reporting a staff contact frequency of two to three times a year.	with members on a recurring basis. • Focus on documenting team contacts with member support system(s) in a consistent fashion, to ensure this measure is being accurately captured.
S7	Individualized Substance Abuse Treatment	1 – 5 1	The ACT CC and the SAS both reported that the team does not currently provide individualized substance abuse treatment. The SAS recently joined the team in June 2016, and reports that she is in the process of engaging members for treatment programming. Though the team does not provide individualized treatment at this time, staff reported that members have not been recently referred to external providers for treatment.	• The ACT team must provide members with substance-use disorders an average of 24 minutes per week or more in formal substance abuse treatment. (i.e., not only ancillary to regular contacts). • Engage members in treatment through the team. Interventions should align with a stage-wise approach, and staff should be able to identify interventions that are most effective with identified stages.
S8	Co-occurring Disorder Treatment Groups	1 – 5 3	The ACT team offers two co-occurring treatment groups weekly, one in the clinic and the second held at a community housing facility where a portion of the ACT members reside. Approximately 23% of all members diagnosed with co-occurring disorders attended one of the substance abuse treatment groups over a month period. Though the clinic-based group is exclusive to ACT members, reviewers were notified that non-ACT, PIR members were not excluded from attending the community housing group.	• Continue to outreach members with co-occurring treatment disorders; working towards a member participation rate of 50% or higher. • Ensure that co-occurring treatment groups are exclusive to ACT members. These groups are designed to be focused on the specific needs of members in needs of treatment for comorbidities.
S9	Co-occurring Disorders (Dual Disorders) Model	1 – 5 3	The team uses a mixed-model of both traditional and dual disorders (DD) principles. Some of the ACT staff were recently trained in Integrated Dual Diagnosis Treatment (IDDT). Many staff were able	• Cross-train all staff in IDDT principles. Members benefit from consistent use of best practice approaches. As staff are trained, they will have a shared

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			to articulate and provide examples of harm reduction tactics they have used with members. Though the language used by staff was reflective of a DD approach, less than half of the team has been trained in IDDT. Further conversations revealed that some staff still embraces the use of detox programs and other confrontational approaches (such as urinary drug screens) as treatment paradigms.	understanding of effective treatment interventions for DD members.
S10	Role of Consumers on Treatment Team	1 – 5 5	The team has a full-time, fully integrated, Peer Support Specialist. The PSS provides direct services to members and his case management duties are equivalent to those of the other team specialists. The PSS shares his personal recovery experiences with members, and additionally provides language interpretation services for ACT members in need of English-to-Spanish translation.	
Total Score:		**3.29**		

ACT FIDELITY SCALE SCORE SHEET

Human Resources	Rating Range	Score (1-5)
1. Small Caseload	1-5	5
2. Team Approach	1-5	4
3. Program Meeting	1-5	5
4. Practicing ACT Leader	1-5	2
5. Continuity of Staffing	1-5	1
6. Staff Capacity	1-5	2
7. Psychiatrist on Team	1-5	4
8. Nurse on Team	1-5	5
9. Substance Abuse Specialist on Team	1-5	3
10. Vocational Specialist on Team	1-5	3
11. Program Size	1-5	5
Organizational Boundaries	Rating Range	Score (1-5)
1. Explicit Admission Criteria	1-5	4
2. Intake Rate	1-5	4
3. Full Responsibility for Treatment Services	1-5	2
4. Responsibility for Crisis Services	1-5	3
5. Responsibility for Hospital Admissions	1-5	3
6. Responsibility for Hospital Discharge Planning	1-5	4

7. Time-unlimited Services	1-5	5
Nature of Services	Rating Range	Score (1-5)
1. Community-Based Services	1-5	3
2. No Drop-out Policy	1-5	4
3. Assertive Engagement Mechanisms	1-5	4
4. Intensity of Service	1-5	2
5. Frequency of Contact	1-5	2
6. Work with Support System	1-5	1
7. Individualized Substance Abuse Treatment	1-5	1
8. Co-occurring Disorders Treatment Groups	1-5	3
9. Co-occurring Disorders (Dual Disorders) Model	1-5	3
10. Role of Consumers on Treatment Team	1-5	5
Total Score	**3.29**	
Highest Possible Score	**5**	